

## BLOOD PRESSURE PROFILES AND DEMOGRAPHIC FACTORS AMONG ADULTS IN A RURAL INDONESIAN COMMUNITY: FINDINGS FROM A COMMUNITY-BASED SCREENING

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### ABSTRACT

*Background: Hypertension is a major modifiable cardiovascular risk factor, and community-based screening may facilitate early identification of people with elevated blood pressure. Objective: To describe blood pressure findings among residents of Mojorembun Village and examine their association with age, sex, smoking status, occupation, and posyandu (community integrated health post) activity. Methods: A cross-sectional observational analysis was conducted using secondary data from 132 adults who attended a community health screening in Mojorembun Village, Rejos District, Nganjuk Regency, East Java, Indonesia, on 19 July 2026. Descriptive statistics were followed by Pearson's Chi-square test (Fisher's exact test where expected cell counts were small), with a two-sided  $\alpha=0.05$ . Blood pressure categories were retained as recorded in the screening dataset; for association analysis, stage 1 and stage 2 were combined as hypertension status, while normal and pre-hypertension/elevated were combined as non-hypertension. Results: Mean age was  $56.67 \pm 14.47$  years, mean systolic blood pressure was  $146.83 \pm 25.73$  mmHg, and mean diastolic blood pressure was  $80.53 \pm 14.46$  mmHg. A total of 110 participants (83.3%) were recorded in the stage 1 or stage 2 categories. Age group was significantly associated with hypertension status ( $p=0.001$ ), whereas sex ( $p=0.506$ ), smoking status ( $p=1.000$ ), occupation ( $p=0.184$ ), and posyandu activity ( $p=0.563$ ) were not. Conclusion: A high proportion of screened participants had blood pressure categorized as stage 1 or stage 2, and age was associated with hypertension status. The findings should be interpreted as screening results rather than population prevalence or definitive clinical diagnoses. Repeated standardized measurement and linkage to primary health care are needed.*

*Keywords: blood pressure; hypertension; community screening; age; rural community*

### INTRODUCTION

Hypertension is a major modifiable risk factor for cardiovascular disease, stroke, chronic kidney disease, and premature mortality, and it remains one of the leading contributors to the global burden of disease [1,12,14]. The NCD Risk Factor Collaboration (NCD-RisC) estimated that 1.28 billion adults aged 30–79 years were living with hypertension in 2019, while major gaps persisted in detection, treatment, and control, particularly in low- and middle-income countries [1]. Long-term

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population-based analyses of blood pressure trends further indicate that the burden has shifted disproportionately toward low- and middle-income countries over the past four decades [12,13]. The World Health Organization (WHO) likewise identifies uncontrolled hypertension as an important contributor to cardiovascular morbidity, stroke, premature death, and economic burden [2].

The burden is also substantial in Southeast Asia. A systematic review and meta-analysis of urban populations reported a pooled hypertension prevalence of 33.82% and identified age, sex, socioeconomic characteristics, body mass index, waist circumference, smoking, and dyslipidaemia among commonly reported risk factors [3]. Comparable patterns have been observed globally, where age, adiposity, and modifiable behavioral factors consistently predict hypertension risk and where control rates remain low even in settings where treatment is available [13,15]. In Indonesia, national survey findings show a considerable gap between measured blood pressure and previously diagnosed hypertension. The 2023 Indonesian Health Survey (SKI 2023) reported hypertension based on blood pressure measurement in 30.8% of adults aged  $\geq 18$  years, while the prevalence among people aged  $\geq 15$  years was 29.2%; East Java had a measured prevalence of 32.8% among those aged  $\geq 15$  years [4]. WHO's country profile for Indonesia similarly highlights hypertension as a leading modifiable cardiovascular risk factor and underscores the persistent gap between measured blood pressure and diagnosed or treated hypertension [18].

Hypertension is frequently asymptomatic, making blood pressure measurement an essential component of detection. WHO recommends accurate blood pressure measurement, confirmation of elevated readings, cardiovascular risk assessment, and appropriate management within primary health care [2,5]. Measurement quality depends on the use of validated automated devices, an appropriately sized cuff, correct patient preparation and positioning, and trained personnel [9,16,19]. Community-based screening, including models led by non-physician or lay health workers, can complement routine health services by reaching people who may not undergo regular assessment [20]. However, screening results obtained on a single occasion should not be equated with clinical diagnosis [2,5].

Age is consistently associated with increasing blood pressure and hypertension risk [1,12]. Indonesian district-level evidence based on Riskesdas 2018 also demonstrated substantial geographic and age-related inequalities in hypertension across 514 districts [6]. Sex differences in blood pressure and hypertension have been documented across the life course, although the magnitude of these differences varies with age and other biological and social factors [7]. Smoking is another important cardiovascular exposure; a 15-year Indonesian population-based cohort study found that changes in smoking status were associated with changes in blood pressure, with differences between men and women [8].

Although national surveys provide population-level estimates, local community screening data can identify groups requiring further assessment and can inform the design of community-to-primary-care referral pathways [5,17,20]. Therefore, this study aimed to describe blood pressure findings among residents of Mojorembun Village



and examine the association between hypertension status and age, sex, smoking status, occupation, and posyandu activity.

## **METHODS**

### **Study design and setting**

This study used a cross-sectional observational design and analyzed secondary data from a community health screening conducted in Mojorembun Village, Rejoso District, Nganjuk Regency, East Java, Indonesia, on 19 July 2026.

### **Participants and data source**

All 132 screening records containing complete data on blood pressure and the main participant characteristics were included. Participants were community members who voluntarily attended the screening activity; the sample therefore represents a convenience sample of screening attendees rather than a probability sample of the village population.

### **Variables and operational definitions**

Blood pressure was recorded in mmHg and separated into systolic and diastolic values. The original screening record classified participants into four categories — normal, pre-hypertension/elevated, hypertension stage 1, and hypertension stage 2 — following a staged classification consistent with contemporary blood pressure guidelines [9,11]. For the association analysis, stage 1 and stage 2 were combined into a single hypertension-status category, while normal and pre-hypertension/elevated were combined as non-hypertension. Age was grouped as <45, 45–59, and ≥60 years. Other variables analyzed were sex, smoking status, occupation, and posyandu activity. Occupational was defined as the respondent's primary occupational status at the time of the study. Respondent were classified into the following categories: housewife, farmer, self-employed, student, village government officer and unemployed

### **Blood pressure measurement**

Accurate blood pressure measurement requires standardized preparation and positioning, an appropriate cuff, a validated device, and procedures designed to reduce measurement error [9,16,19]. In the present screening, blood pressure was measured using a digital blood pressure monitor. The device brand was TensiOne with an adult-sized cuff. The adult cuff was used according to the available equipment and was intended for adult participant. Measurement were performed using standardized blood pressure measurement procedures, including appropriate participant positioning and rest before measurement, as applicable to the screening protocol, participant position (seated/supine, back and arm support); and the training or qualification of the personnel who performed the measurements

### **Statistical analysis**



Continuous variables were summarized using mean and standard deviation. Categorical variables were summarized using frequency and percentage. Associations between categorical characteristics (age group, sex, smoking status, occupation, and posyandu activity) and hypertension status were assessed using Pearson's Chi-square test, with Fisher's exact test applied instead whenever more than 20% of the cells in a contingency table had an expected count below five (as was the case for the smoking-status cross-tabulation). A two-sided  $p$ -value  $<0.05$  was considered statistically significant. The analysis was exploratory, and given the cross-sectional design, findings were not intended to establish causality. Analyses were performed using statistical software IBM SPSS Statistics version XX.

### Ethical considerations

This study used secondary data obtained from community-based blood pressure screening activity conducted in Mojorembun Village, Rejoso District, Nganjuk Regency, East Java, Indonesia. Permission to use the screening data for secondary analysis was obtained from Rejoso Community Health Center. The dataset provided for analysis contained no direct personal identifiers. Individual identifying information, including names and addresses, was not collected for the present analysis or reported in the manuscript. All results are presented in aggregate form to protect participants' confidentiality. The ethical review requirement for secondary use of the screening data were assessed in accordance with the policies of Nganjuk Regency Health Office.

### RESULTS

Table 1 (see Tables section after the References) shows the demographic and selected behavioral characteristics of the 132 participants included in the community-based blood pressure screening. The majority of participants were female (67.4%), while males accounted for 32.6%. Nearly half of the participants were aged  $\geq 60$  years (47.7%), followed by those aged 45–59 years (33.3%) and  $<45$  years (18.9%). Most participants were non-smokers (78.0%), whereas 22.0% reported smoking. Regarding posyandu participation, 33.3% of participants were actively involved, while 66.7% were classified as not active. Overall, the screening population was predominantly female, older adults, non-smokers, and participants who were not actively involved in posyandu activities.

Table 2 shows the distribution of blood pressure categories among the 132 participants who underwent community-based screening. The majority of participants were categorized as having stage 2 hypertension (62.1%), followed by stage 1 hypertension (21.2%). Meanwhile, 8.3% of participants had normal blood pressure and another 8.3% were categorized as having pre-hypertension/elevated blood pressure. Overall, 110 participants (83.3%) were recorded in the stage 1 or stage 2 hypertension categories.

Table 3 presents the association between demographic and behavioral characteristics and recorded hypertension status. Age group was significantly associated with hypertension status ( $p=0.001$ ): the proportion classified as

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hypertensive was 60.0% among participants aged <45 years, 93.2% among those aged 45–59 years, and 85.7% among those aged ≥60 years. No statistically significant association was observed for sex ( $p=0.506$ ), smoking status ( $p=1.000$ ), occupation ( $p=0.184$ ), or posyandu activity ( $p=0.563$ ). These results indicate an association between age group and recorded hypertension status in this screening sample; given the cross-sectional design, they should not be interpreted as evidence of a causal relationship.

## DISCUSSION

The main finding of this study was the high proportion of participants whose screening records were categorized as stage 1 or stage 2 hypertension, together with a significant association between age group and hypertension status. Importantly, the 83.3% figure should not be interpreted as the prevalence of hypertension in Mojorembun Village. Participants were self-selected attendees of a single screening activity, and blood pressure was recorded on one occasion. National estimates such as SKI 2023 are population-representative survey estimates obtained using standardized measurement procedures and are not directly comparable with results from this single-occasion community screening sample [4].

The mean systolic blood pressure was 146.83 mmHg, indicating that systolic elevation was prominent in the screened group. This finding is consistent with the well-established increase in blood pressure with advancing age. Global analyses demonstrate that ageing contributes substantially to the increasing number of adults living with hypertension [1,12], while Indonesian district-level analyses show marked differences in hypertension across age groups and geographic areas [6].

Age was the only characteristic significantly associated with hypertension status in the present analysis. The proportion classified as hypertensive increased from 60.0% in participants aged <45 years to 93.2% in those aged 45–59 years and remained high at 85.7% among those aged ≥60 years. The association is biologically plausible because arterial stiffness, vascular structural changes, and cumulative exposure to cardiovascular risk factors increase with age [1,6]. Consistent with contemporary guidelines that recommend confirmatory or repeated measurement before a diagnosis of hypertension is established [2,11], the elevated proportions observed here should prompt repeat assessment rather than immediate diagnostic labelling. The cross-sectional design does not permit causal inference, and the non-monotonic pattern between the 45–59 and ≥60 groups should be interpreted cautiously.

Sex was not significantly associated with hypertension status. This result should not be interpreted as evidence that sex is irrelevant to blood pressure. Evidence indicates sex-related differences in blood pressure trajectories and hypertension risk across the life course, influenced by biological, hormonal, behavioral, and social factors [7]. The present sample contained more women than men, and the relatively small male subgroup may have limited statistical power to detect differences.

Smoking status was also not significantly associated with hypertension status. The absence of statistical significance may partly reflect the limited number of smokers (29

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participants), the small expected cell counts that required the use of Fisher's exact test, and the crude measurement of smoking exposure. The dataset did not capture smoking duration, cigarettes per day, pack-years, or time since cessation. In contrast, a 15-year population-based cohort study in Indonesia found that changes in smoking status were associated with changes in blood pressure [8]. Future screening should therefore collect more detailed tobacco-exposure information.

Occupation was not significantly associated with hypertension status ( $p=0.184$ ). However, the distribution of participants across occupational categories, was unequal, with the largest group being farmer ( $n=41$ ), self-employed ( $n=37$ ), and housewives ( $n=31$ ), while smaller groups include village government officer ( $n=8$ ), teacher ( $n=8$ ), unemployed participants ( $n=6$ ) and students ( $n=1$ ). The small number of participants in some occupational categories particularly student and unemployed participants, may have limited the statistical power and resulted in small expected frequencies in some cells, thereby requiring cautious interpretation of the findings. Furthermore, occupational category is a board proxy and may not adequately capture the specific work-related exposures that may influence blood pressure, such as physical activity, sedentary behavior, psychosocial stress, work shcedules, sleep patterns, and socioeconomic conditions.

Posyandu activity was not significantly associated with hypertension status. Rather than being interpreted as a direct biological risk factor, posyandu participation may be considered an indicator of access to or use of community health services. Community-based programs can provide an important platform for repeated blood pressure measurement, education, risk-factor assessment, and referral. Evidence from Southeast Asia supports the need for community and primary prevention activities [3], non-physician-led community screening models have shown feasibility for reaching underserved populations [20], and WHO HEARTS provides a framework, including risk-based approaches, for integrating cardiovascular risk management into primary health care [5,10,17].

The findings have practical implications for rural cardiovascular prevention. Community screening is valuable when it functions as the first step in a screening-to-care pathway. Individuals with elevated readings should receive repeat standardized measurements, risk assessment, lifestyle counseling, and referral when clinically indicated. Accurate measurement is fundamental: the American Heart Association and related expert guidance emphasize validated devices, correct cuff selection, appropriate patient preparation and positioning, and standardized procedures [9,19].

The study also highlights the need to improve documentation of community screening procedures. The current dataset does not specify the blood pressure device, its validation status, cuff size, number of measurements, rest interval, or measurement personnel. These details should be documented in future activities because measurement quality directly affects classification and comparability with national surveys and clinical guidelines [9,16].

## Strengths and limitations



This analysis benefits from a reasonably large screening sample ( $n=132$ ) with complete blood pressure and demographic data, and it applies statistically appropriate methods (Fisher's exact test where expected cell counts were small). However, several limitations should be considered. First, participants were a convenience sample of screening attendees rather than a probability sample of the village population, so findings should not be generalized as village-level prevalence. Second, blood pressure was measured on a single occasion, which does not meet the confirmatory measurement standard recommended for a clinical diagnosis of hypertension [2,5,11]. Third, key details of the measurement protocol (device validation, cuff size, rest period, number and interval of readings, and personnel training) were not available in the source dataset. Fourth, the unequal distribution and relatively small sample sizes in several occupational categories may have reduced the statistical power of the analysis and resulted in small expected cell frequencies, which currently limits the depth of interpretation for this variable. Finally, the cross-sectional design precludes causal inference for all reported associations.

## CONCLUSION

Among 132 adults attending a community health screening in Mojorembun Village, mean systolic and diastolic blood pressures were  $146.83 \pm 25.73$  mmHg and  $80.53 \pm 14.46$  mmHg, respectively. A total of 83.3% of participants were recorded in the stage 1 or stage 2 categories. Age group was significantly associated with hypertension status, whereas sex, smoking status, occupation, and posyandu activity were not. These findings support repeated, standardized community blood pressure screening linked to confirmation and follow-up through primary health care. The 83.3% estimate should be interpreted as a screening finding rather than population prevalence or a definitive clinical diagnosis.

## IMPLICATIONS FOR NURSING PRACTICE AND COMMUNITY HEALTH SERVICE

Community health activities in rural Indonesia can strengthen hypertension detection by integrating standardized blood pressure measurement, documentation of cardiovascular risk factors, brief lifestyle counseling, repeat measurement of elevated readings, and referral to primary health care. Posyandu and village-level health activities can function as access points for repeated screening and health education, while primary care should provide diagnostic confirmation, risk assessment, treatment when indicated, and longitudinal monitoring [2,5,10,17].

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## ETHICAL STATEMENT AND CONFLICT OF INTEREST

This study analyzed data obtained from a community-based blood pressure screening activity conducted in Mojorembun Village, Rejos District, Nganjuk Regency, East Java, Indonesia. The activity was conducted as community health screening program rather than as a prospective research study, and no identifiable personal information is reported in this manuscript. Ethical review requirements were considered in accordance with the policies of the author's institution and the applicable regulations. The authors declare no conflict of interest.

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## TABLES

Note: No figures are included, as the original screening dataset did not contain figure-ready raw data (e.g., individual-level plots). Only tables are presented below, as requested.

**Table 1.** Demographic and behavioral characteristics of participants (n=132).

| Characteristic   | n  | %    |
|------------------|----|------|
| <b>Sex</b>       |    |      |
| Male             | 43 | 32.6 |
| Female           | 89 | 67.4 |
| <b>Age group</b> |    |      |
| <45 years        | 25 | 18.9 |
| 45–59 years      | 44 | 33.3 |



|                            |     |      |
|----------------------------|-----|------|
| ≥60 years                  | 63  | 47.7 |
| <b>Smoking status</b>      |     |      |
| Smoker                     | 29  | 22.0 |
| Non-smoker                 | 103 | 78.0 |
| <b>Occupation</b>          |     |      |
| Housewife                  | 31  | 23.6 |
| Farmer                     | 41  | 31.0 |
| Self-employed              | 37  | 28.0 |
| Teacher                    | 8   | 6.0  |
| Village government officer | 8   | 6.0  |
| Student                    | 1   | 0.8  |
| Unemployed                 | 6   | 4.6  |
| <b>Posyandu activity</b>   |     |      |
| Active posyandu            | 44  | 33.3 |
| Not active                 | 88  | 66.7 |

**Table 2.** Distribution of recorded blood pressure categories among participants in the community-based screening (n=132).

| Blood pressure category recorded | n          | %            |
|----------------------------------|------------|--------------|
| Normal                           | 11         | 8.3          |
| Pre-hypertension/Elevated        | 11         | 8.3          |
| Hypertension stage 1             | 28         | 21.2         |
| Hypertension stage 2             | 82         | 62.1         |
| <b>Total</b>                     | <b>132</b> | <b>100.0</b> |



Percentages may not sum to exactly 100.0% due to rounding.

**Table 3.** Association between demographic and behavioral characteristics and recorded hypertension status among screening participants (n=132).

| Variable/category          | Non-HTN n (%) | HTN n (%) | Total | p-value                  |
|----------------------------|---------------|-----------|-------|--------------------------|
| <b>Age group</b>           |               |           |       | <b>0.001</b>             |
| <45 years                  | 10 (40.0)     | 15 (60.0) | 25    |                          |
| 45–59 years                | 3 (6.8)       | 41 (93.2) | 44    |                          |
| ≥60 years                  | 9 (14.3)      | 54 (85.7) | 63    |                          |
| <b>Sex</b>                 |               |           |       | <b>0.506</b>             |
| Male                       | 9 (20.9)      | 34 (79.1) | 43    |                          |
| Female                     | 13 (14.6)     | 76 (85.4) | 89    |                          |
| <b>Smoking status</b>      |               |           |       | <b>1.000<sup>a</sup></b> |
| Non-smoker                 | 17 (16.5)     | 86 (83.5) | 103   |                          |
| Smoker                     | 5 (17.2)      | 24 (82.8) | 29    |                          |
| <b>Occupation</b>          |               |           |       | <b>0.184</b>             |
| Housewife                  | 27 (87.1)     | 4 (12.9)  | 31    |                          |
| Farmer                     | 36 (87.9)     | 5 (12.2)  | 41    |                          |
| Self-employed              | 31 (83.6)     | 6 (16.2)  | 37    |                          |
| Teacher                    | 5 (62.5)      | 3 (37.5)  | 8     |                          |
| Village government officer | 6 (75.0)      | 2 (25.0)  | 8     |                          |
| Student                    | 0 (0)         | 1 (100)   | 1     |                          |
| Unemployed                 | 5 (83.3)      | 1 (16.7)  | 6     |                          |
| <b>Posyandu activity</b>   |               |           |       | <b>0.563</b>             |
| Active posyandu            | 9 (20.5)      | 35 (79.5) | 44    |                          |



Not active

13 (14.8)

75 (85.2)

88

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